STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005698	A. BUILDING _____ B. WING _____	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOORINGS OF ARLINGTON HEIGHTS	761 OLD BARN LANE ARLINGTON HTS, IL 60005

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Final Observations Licensure Violations: 300.7020b)2)6) Section 300.7020 Assessment and Care Planning b) The care plan shall be developed by an interdisciplinary team within 21 days after the resident's admission to the unit or center. The interdisciplinary team shall include, at least, the attending physician, a nurse with responsibility for the resident, other appropriate staff in disciplines as determined by the resident's needs, the resident, the resident's representative, and the certified nursing assistant (CNA) who is primarily responsible for this resident's direct care, or an alternate, if needed, to provide input and gain insight into the care plan. Others may participate at the discretion of the resident. 2) As new behaviors manifest, the behaviors shall be evaluated and addressed in the care plan. 6) The care plan shall be implemented and followed by staff who care for the resident. This requirement is NOT MET as evidenced by: Based on interview and record review, the facility failed to revise and implement fall prevention care plans for one of five resident (R13), reviewed for falls, in the sample of 15. Findings include: R13 is an 88 year old admitted to the facility on 12/2715 for long term nursing rehabilitation. Face sheet dated 7/12/16 has diagnoses listed in part: dementia with behavioral disturbances, altered mental status, dysphagia, type 2 diabetes mellitus, hyperlipidemia and hypothyroidsm. Incident reports indicate R13 fell 10 times and sustained minor injuries in three of the 10 falls.	S9999	**Attachment A** **Statement of Licensure Violations**	

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Interview with E16 (Care Plan Coordinator) on 7/13/16 at 2:00 PM indicated that E16 was the care plan coordinator in charge of care plans and created the care plan for R13. E16's signed statement indicated, "I do quarterly/annual and scheduled care plans and update them. In between those times the manager or nurses on the floor enters whatever updates as it occurs such as falls, skin tears. The IDT (interdisciplinary team) has input on the care plans so they will update me on things such as falls."

Interview with E15 (Nurse) on 7/13/16 at 2:35 PM indicates that E15 is the nurse for R13 but is not that familiar with the resident since E15 has only been working on the floor for several weeks. Asked if E15 knew if R13 was a fall risk, E15 stated, "I think so, but [R13] hasn't fallen as far as I know." Asked what E15 does for R13 to prevent falling, E15 stated, "Well we put [R13] by the nurses station most of the time."
E15 was not able to elaborate further on any other interventions.

Interview with E18 (certified nurses aide) on 7/13/16 at 2:45 PM indicated that E18 usually takes care of R13 and states in part: "we help [R13] with all is ADLs (activities of daily living) but [R13] is closer to independence than not. [R13] tries to stand up so is a fall risk. I'm not sure exactly what things we have in place to keep [R13] from falling other than watching [R13]."

R13's Minimum Data Set (MDS) dated 3/31/16 and 6/23/16 Section G for Functional Status indicates R13 requires extensive assistance for most activities of daily living such as toileting, transfers from bed to chair and moving on and off the unit.

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R13's care plan dated 4/6/16 states in part: "R13 is high risk for falls related to history of multiple falls. Goals: will not sustain any serious injuries related to falls until next review. Interventions: remind to call for assistance prior to transfers or walk; environment free of hazards; PT/OT eval and screen needed; reorient to room, washroom and call light use as needed."

Review of facility occurrence logs lists R13 falling a total of 10 times in a seven month time span. In the 10 times R13 fell, the facility made only five minor changes to the care plan to prevent R13 from falling.

R13's fall risk assessment indicate a high risk for falls with the facility performing five additional fall risk assessments out of the 10 falls sustained.

Facility policy on falls dated 11/2008 titled "Assessment, Documentation and Care Planning for HC Residents at Risk for Falls or Who Have Fallen" lists in part:
Purpose: " to ensure that appropriate risk assessment, documentation and care planning are completed for residents at risk for falls or who have fallen.
Staff will: Assess, develop interventions, and/or revise the plan of care for a resident who has experienced falls, or who is identified as having risk factors for falling; Address the factors for the fall; Revise the resident plan of care and /or facility practices, as needed, to reduce the likelihood of another fall.

(B)

Section 300.7060 Environment

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a) The environment (cultural, social, and physical) shall support the function of the cognitively impaired residents. It shall accommodate behaviors, maximize functional abilities, promote safety, and encourage residents' independence by compensating for losses resulting from the disease process in accordance with each resident's care plan.

This requirement was NOT MET as evidenced by:

Based on observation, interview and record review, the facility failed to secure personal hygiene products to limit access and promote safety for two of seven residents (R9, R12) in the sample of fifteen and one resident (R19) from the supplemental sample, reviewed for a safe environment in the Alzheimer's/Dementia specialty care unit.

Findings include:

On 7/12/16 at 11:48 AM, the bathroom shared by R9 and R12 was observed to have two unlatched medicine cabinets, each containing a toothbrush and toothpaste. The cabinet to the right was marked to indicate R9's bed, and also contained a jar of facial cream. In the corner of the bathroom was a three-drawer plastic storage unit that contained multiple bottles of hand lotion, a small bottle of dish detergent, and shampoo. The lower drawer was noted to contain wipes and tissues.

On 7/12/16 at 12:32 PM, E7 (Nurse) stated that shampoos, lotions, nail polish, nail clippers and other personal care items must be stored so residents on the Speciality Care Unit (SCU)

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cannot get access to them. E7 stated resident toiletries are placed in bins on the upper shelf in resident closets. When asked about the storage unit in the bathroom of R9 and R12, E7 appeared surprised and asked to see the unit. Upon inspection of the bathroom storage bin, a pair of nail clippers were noted in the bottom of the lowest drawer with a box of tissues and wipes, in addition to the lotions, soaps and creams in the top two drawers. E7 stated the items should not be in the room and stated certified nurse aides would be asked about the items. E7 identified R19 as a resident who is most likely to wander and rummage in resident rooms.

On 7/13/16 at 11:51 AM, E4 (Nurse Manager) stated both R12 and R19 were residents with wandering behaviors in the SCU.

On 7/13/16 at Daily status meeting, E2 (Director of Nursing) stated the storage bin was brought in by R9's son who transferred R9's belongings. R9 was admitted to the SCU on 3/8/16 and previously lived in the Assisted Living section.

R9's face sheet lists a diagnosis of Dementia with behavioral disturbances. R9's care plan includes a Problem/Need that reads "3/8/16 - Resident has had episodes of wandering in assisted living prior to moving to SCU. 4/20/16 - Resident ambulates within unit but has not been exit seeking at this time." R9's MDS (Minimum Data Set) of 6/9/16 indicates R9 has exhibited physical and verbal behaviors directed toward others and that R9's behavior is worse when compared to the prior assessment.

R12's face sheet lists a diagnosis of Dementia with behavioral disturbances. R12's care plan includes a Problem/Need that includes "5/13/15 -

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Resident has tendency to wander within unit. 6/8/16 - Resident continues to pace and wander within unit." R12's MDS (Minimum Data Set) of 6/2/16 indicates R12's cognitive skills are severely impaired and that R12 has behavioral symptoms not directed toward others one to three days in the seven day look-back period.

R19's face sheet lists a diagnosis of Dementia with behavioral disturbances. R12's care plan includes a Problem/Need that reads"3/23/16 - Resident continues to wander within unit and in other rooms." On 7/12 16 prior to the lunch period, R19 was observed continuously walking on the unit with and without staff escort.

The facility policy, Accidents and Supervision, dated 12/17/12, reads in part: "Hazards refer to elements of the resident environment that have the potential to cause injury or illness. Physical Plant Hazards: All staff (e.g. professional, administrative, maintenance, etc.) are to be involved in observing and identifying potential hazards in the environment, while taking into consideration the unique characteristics and abilities of each resident."

The facility document "The Special Care Unit Program" reads in part: "Role of the Family - Families are informed regarding personal items for their loved ones. We encourage clothes that are comfortable for the resident. No chemicals or sharp objects are allowed in the resident's room. Personal items such as soaps, lotions, shampoos should be kept in the containers on the resident's closet shelf."

(B)